United States Senate

WASHINGTON, DC 20510

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SPECIAL COMMITTEE ON AGING

February 14, 2019

The Honorable Robert Wilkie Secretary U.S. Department of Veterans Affairs 810 Vermont Avenue, NW Washington, D.C. 20420

Dear Secretary Wilkie:

I write to express concern with substantiated whistleblower allegations regarding lengthy wait times at the Orlando VA Medical Center (VAMC), which were publicly disclosed by the Office of Special Counsel last week. After an investigation into the matter, your Department found that approximately 453 Veteran patients seeking care at this facility experienced wait times for endoscopy procedures longer than 30 days. While I applaud the VA for investigating these allegations and recommending corrective actions, there are two matters I request you to address.

The Veterans Choice Program enables Veterans enrolled in VA health to receive care from community providers when wait times for appointments exceed 30 days. Despite these wait times and clearly outlined protocols, the investigation found that the Acting Chief of Medicine of Orlando VAMC instructed staff to not refer some of these patients to community care. The report states that Orlando VAMC staff failed to follow Veterans Health Administration Policy and Veterans Choice Program rules to offer outside care. As such, I request information on what actions your Department has taken to ensure all Orlando VAMC staff, in all departments, are strictly adhering to VA policy and rules regarding community care.

The VA concluded that a "substantial and specific danger to public health and safety exists at Orlando." The VA's investigation noted that wait times between preliminary evaluations and colonoscopies appeared to be increasing. These delays raised the risk for medical conditions to worsen, and potentially impede the ability to complete a colonoscopy. I am concerned that this poses a substantial danger and could threaten patient outcomes. Further, it is my understanding that your department has not taken any disciplinary action to hold the responsible personnel accountable for these violations. The delays and failure to refer Veterans to the Veterans Choice Program are unacceptable and must be prevented from happening in the future. I would appreciate an explanation on disciplinary actions that have been executed, and if there are none, the reason.

I look forward to your response, and working with you to ensure that our veterans are receiving appropriate care in a timely fashion.

Sincerely,

Marco Rubio

U.S. Senator